MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09255

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County: St Mary's

City or town: Charlotte Hall

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: St Marys

City or town: Charlotte Hall

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles Braxton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

8.(b) Name of husband or wife: Jeanette Shorter

7. Birth date of deceased (mo., day, yr.): Feb 8, 1882 — 6.(c) If alive, give age ? years

8. AGE:

Years	Months	Days	If less than one day
63	7	11	...hrs. ...min.

9. Birthplace: Charlotte Hall Md. (Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business

FATHER

12. Name: William Braxton

13. Birthplace: Va.

MOTHER

14. Maiden name: Emily Weir

15. Birthplace: St Marys

18. Informant: Jeanette Braxton

Address: Charlotte Hall

17. Buried (Burial, cremation, or removal. Which?) Date thereof 9-23-45 (month) (day) (year)

Cemetery or crematory: Mt Calvery

Location: St Marys Co.

18. Funeral director: Elmer M. Wade

Address: Hughesville, Md.

19. 9/20 19 45 (Date rec'd by registrar) Julia A. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 19 19 45 at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/12/45 19 to 7/20/45 and that I last saw h... alive on 7/8/45 19

Immediate cause of death	DURATION
Coronary Occlusion	
Arterial Hypertension	
Coronary Heart Disease	
Due to: Cardiac Decompensation	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Daniel A Fisher M. D. or other

Address: Hughesville Date signed 9/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (172)

CERTIFICATE OF DEATH

09258

Reg. Dist. No. 282

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County St Mary's Co

City or town Chesapeake Bay Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County Arlington

City or town Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 5701 - 11th Rd. Nor. Arlington

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME MARY ELIZABETH COWAN

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife None

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28 - 1916

8. AGE: Years 28 | Months 11 | Days 20 | If less than one day hrs. min.

9. Birthplace China Grove N.C. (Town, county, and state)

10. Usual occupation Clerk

11. Industry or business War Dept.

FATHER 12. Name Garner Sidney Cowan

13. Birthplace China Grove N.C.

MOTHER 14. Maiden name Mary F. Cooper

15. Birthplace Mocksville N.C.

16. Informant Virginia O Bradshaw

Address 172 S. Prospect Lenoir N.C.

17. Removed (Burial, cremation, or removal. Which?) Date thereof 9/13/45 (month) (day) (year)

Cemetery or crematory Wash. D.C.

Location

18. Funeral director W. W. Chambers Co.

Address 3072 M. at. N.W. D.C.

19. 9/12 1945 Camalier

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8th 1945, at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1945

and that I last saw h alive on 19

Immediate cause of death	Accidental Drowning	DURATION
Due to	having slipped and fallen over board	
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Sept 8 1945

Where did injury occur? Chesapeake Bay (City or town) (County) Md (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work? Vacationing

23. SIGNATURE Francis F. Freeman M.D. M. D. or other

Address Leonardtown Date signed 9-12-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (172)

CERTIFICATE OF DEATH

09257 ★

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: St Mary's Co.

County Chesapeake Bay

City or town ..... Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, Institution, or street address where death occurred:

.....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County Arlington

City or town .....

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1302 Lee Highway

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME EMMETT J. GODSEY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Bettie D. Godsey

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 7th 1908

8. AGE: Years 36 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace N. J. (Town, county, and state)

10. Usual occupation Physician (Chiropractic)

11. Industry or business Self.

FATHER 12. Name unknown

13. Birthplace ( )

MOTHER 14. Maiden name unknown

15. Birthplace ( )

16. Informant Mrs Irene Brill

Address 1910 C. St. N.E.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 9/12/45 (month) (day) (year)

Cemetery or crematory .....

Location .....

18. Funeral director W. W. Chambers Co

Address 3072 M. St. N.W. D.C.

19. 9/13 1945 Canalier

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8th 1945, at 8-P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 8 1945, to Sept 12 1945

and that I last saw ..... alive on ..... 19.....

Immediate cause of death	DURATION
Accidental Drowning	
Due to Effort to save a drowning	
Due to Concussion	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9-8-45

Where did injury occur? Chesapeake Bay (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? Vacationing

23. SIGNATURE Francis F. Greenwell Coroner M. D. or other

Address Leonardtown Md. Date signed 9-12-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (123)

CERTIFICATE OF DEATH

09258

Reg. Dist. No. 2-6

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: St. Mary's

City or town: Rural Benedict

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State: Md. County: St. Mary's

City or town: Rural Benedict

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles Henry Hall

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Single.

6.(b) Name of husband or wife —

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) 2-1-1931

8. AGE:

Years	Months	Days	If less than one day
14	7	9	...hrs. ...min.

9. Birthplace Millers Run Md.

(Town, county, and state)

10. Usual occupation Schoolboy

11. Industry or business

FATHER — 12. Name John William Hall

13. Birthplace Charlotte

MOTHER — 14. Maiden name Gladys Mae Chesseldine

15. Birthplace Point of Rocks Md.

16. Informant John W. Hall

Address Benedict Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-12-40 (month) (day) (year)

Cemetery or crematory Sacred Heart

Location Benedict Md.

18. Funeral director W. C. Mattingly & Sons

Address La Plata Md.

19. 9-11-1940 R. V. Palmer

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-10 1940; at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19— to — 19—

and that I last saw him alive on dead 9-10 — 1940

Immediate cause of death Drowning

accidental

DURATION
Instd.

Due to

Due to Washing ground there

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert V. Palmer M. D. or other

Address Avenue Md. Date signed 9-11-1940

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0925

Reg. Dist. No. 282

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County St Marys

City or town near Leonardtown Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 & 2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St Marys

City or town Medleys Neck

(If outside city or town limits, write RURAL and give nearest town)

Street No. Leonardtown Md R.F.D. #1

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Flonie Lucretia Bowles Hicks

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed

6.(b) Name of husband or wife T. M. Hicks

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 8 1881

8. AGE: Years	Months	Days	If less than one day
64	1	16	..... hrs. ..... min.

9. Birthplace Loveville St Marys Md

(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER 12. Name Daniel J. Bowles

13. Birthplace St Marys Co

MOTHER 14. Maiden name Mary Alice Graves

15. Birthplace St Marys Co

16. Informant Mrs Edythe Goldsborough

Address Valley Wood Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 26-1945 (month) (day) (year)

Cemetery or crematory St Johns Cemetery

Location Valley Wood Md

18. Funeral director W C Mattingley Sons

Address Leonardtown Md

19. Sept 29 1945 Caroline (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1945 at 4:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1945 on Sept 23 1945

and that I last saw h alive on 1945

Immediate cause of death	DURATION
Cerebral injuries	
Due to Fractured Skull	
Due to Automobile accident; Coroner on September 23rd 1945	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Sept 23-45

Where did injury occur? 1½ miles south of Leonardtown on Route 5. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) public place

Means of injury automobile accident. Injured at work?

23. SIGNATURE G G Greenwell Coroner M. D. or other

Address Leonardtown Md Date signed Sept 24-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17-a)

09260

CERTIFICATE OF DEATH

Reg. Dist. No. 282

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: St. Marys
City or town: USNAS, Disp., Patuxent River, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 1/2 months
Hospital, Institution, or street address where death occurred:
USNAS, Disp., Patuxent River, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: St Marys
City or town: California
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William Joseph Luczak Jr.

3.(b) Social Security Number: ------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife: --------
6.(c) If alive, give age: ---------- years

7. Birth date of deceased (mo., day, yr.): 9 July 1945

8. AGE:	Years	Months	Days	If less than one day
	---	2	12	--- hrs. --- min.

9. Birthplace: St Marys, Md. (Town, county, and state)
10. Usual occupation: --------
11. Industry or business: ------

FATHER
12. Name: William Joseph Luczak
13. Birthplace: Houston, Texas

MOTHER
14. Maiden name: Leona Dorothy Miller
15. Birthplace: Texas

16. Informant: William J. Luczak
Address: USNAS, Patuxent River, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/23/45 (month) (day) (year)
Cemetery or crematory: St. Aloysius
Location: Leonardtown
18. Funeral director: P B Robinson
Address: Leonardtown
19. 9/23 1945 (Date rec'd by registrar) Canalist Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 21 September 1945, at 2100 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 September 1945 to 21 September 1945 and that I last saw him alive on 21 September 1945

Immediate cause of death	DURATION
ENTERITIS, Acute	4 Days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

Richard H. Driscoll

23. SIGNATURE: Richard H. Driscoll M. D. or other
Address: USNAS, Dispensary, Patuxent River, Md. Date signed 9-21-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

09261

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH:

County St. Marys

City or town Piney Point, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Marys

City or town Piney Point

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Elya Jane Wilson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 8th 1865

8. AGE:

Years	Months	Days	If less than one day
80	8	4	..... hrs. ..... min.

9. Birthplace Piney Point, St Marys, Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name John Briscoe

13. Birthplace St. Marys Co. Md.

MOTHER

14. Maiden name Mary (Unknown) Briscoe

15. Birthplace St. Marys Co. Md

16. Informant Jennie Wilson

Address 241 F. st N.W. Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 15 1945 (month) (day) (year)

Cemetery or crematory St. Georges

Location near Valley Lee, Md

18. Funeral director W. C. Watkins Leonardtown Sons

Address Leonardtown, Md

19. Sept 14 1945 (Date rec'd by registrar) P. J. Beary MD Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12th 1945 at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1944 to Sept. 10 1945 and that I last saw h.er alive on Sept. 10 1945

Immediate cause of death	DURATION
General Arterio sclerosis	
Due to	
Due to	
Other conditions	

(Includs pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE P. J. Beary M.D. M. D. or other

Address Great Mills Md Date signed 9-14-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(9262)

Reg. Diat. No. 282

1. PLACE OF DEATH:

County St. Marys

City or town Wynn, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Marys

City or town Wynn, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Harry A. Myers

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Margaret

6.(c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) June 2 1907

8. AGE: Years 38 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual occupation pipe fitter

11. Industry or business

FATHER 12. Name Jerimiah Myers

13. Birthplace West Virginia

MOTHER 14. Maiden name Mary Bennett

15. Birthplace West Virginia

16. Informant Margaret Myers

Address Wynn, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/7/45 (month) (day) (year)

Cemetery or crematory St. Michaels

Location Ridge, Maryland

18. Funeral director P. B. Robinson

Address Leonardtown, Md.

19. 9/6 1945 (Date rec'd by registrar) Casualier Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 4 1945 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from on 9-4 1945, to ... 19...; and that I last saw h... alive, on ... 19...

	DURATION
Immediate cause of death Fibrillation of heart, acute	
Due to coronary thrombosis	4 weeks
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. J. Greenwell M. D. or other

Address Leonardtown Md. Date signed 9-5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09263

Reg. Dist. No. 282

1. PLACE OF DEATH:
County: St. Mary's
City or town: Patuxent River, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
NAS Dispensary, Patuxent River, Maryland
How long in hospital or institution? Born 25 Sept. 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: St. Mary's
City or town: Patuxent River, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: M.E.M.Q. #708c
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: SMILEY, Baby John Ray III

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

B.(b) Name of husband or wife:
B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 25, 1945

8. AGE: Years	Months	Days	If less than one day
		2	hrs. min.

9. Birthplace: Patuxent River, Maryland (Town, county, and state)
10. Usual occupation: Yeoman first class
11. Industry or business: U. S. Navy

FATHER
12. Name: SMILEY, John Ray
13. Birthplace: Port Huron, Michigan

MOTHER
14. Maiden name: Betty Louise Wray
15. Birthplace: Huntington, West Virginia

16. Informant: Father: John Ray Smiley
Address: US NAS, Patuxent River, Maryland

17. Removal Cremation (Burial, cremation, or removal. Which?) Date thereof: 27 Sept. 1945 (month) (day) (year)
Cemetery or crematory: Robinson's Funeral Home, Washington, D.C.
Location: Leonardtown, Maryland

18. Funeral director: P. B. Robinson
Address: Leonardtown, Md.

19. 9/27 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 27 September 1945 at 1:57 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 25 1945 to Sept. 26 1945 and that I last saw him alive on Sept. 26 1945

Immediate cause of death	DURATION
Intracranial injury	2 days
Due to:	
Due to:	
Other conditions: --	

(Include pregnancy within 3 months of death)

Major findings of operations: --
Date of op.:
Autopsy results: Not done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Howard Royer HOWARD ROYER, Lt. Comdr. (MC) USNR (M. D. or other)
Address: US NAS, Patuxent River, Md. signed: 9-27-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(9264) 282

Reg. Diat. No.

1. PLACE OF DEATH:

County St Marys

City or town Compton Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St Marys

City or town Compton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Felix Albert Somerville

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	colored	married

6.(b) Name of husband or wife Mary Eleanora Somerville

6.(c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) May 15 1895

8. AGE: Yeare	Mooths	Days	If less than one day
50	3	25	hrs. min.

9. Birthplace Compton St Mary's co Md (Town, county, and state)

10. Usual occupation Laborer Boat building

11. Industry or business Oysterman

FATHER 12. Name Thomas Somerville

FATHER 13. Birthplace St Marys co

MOTHER 14. Maiden name Lina Combs

MOTHER 15. Birthplace St Mary's Co

16. Informant Mary Elenora Somerville

Address Compton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 11 1945 (month) (day) (year)

Cemetery or crematory St Francis Xavier Cemetery

Location Compton Md

18. Funeral director W. C. Mattingly Sons

Address Leonardtown Md

19. Oct 1 1945 Camden (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1945 at 1245 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 on 9-9 1945 and that I last saw h alive on 19

Immediate cause of death	DURATION
Crushed Skull	
Due to Collision with Automobile	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9-9-45

Where did injury occur? near Compton St Marys Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public road

Means of injury Hit by Automobile Injured at work? No

23. SIGNATURE F F Greenwell Md Coroner M. D. or other

Address Leonardtown Md Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15